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[For the Medical and Surgical Reporter.]

EMACIATION: A SYMPTOM OF PHTHISIS.

BY A. P. DUTCHER, M. D.,

Of Enon Valley, Lawrence Co., Pennsylvania.

Of all the constitutional symptoms of pulmonary tuberculosis, there is none so prominent and distinctly marked as emaciation. It frequently manifests itself before any other symptom. How often is it the case, that from some unknown cause, we see an individual gradually lose flesh, and after a certain period the symptoms of phthisis will appear so pronounced, that none need be in doubt as to the real nature of the disorder. Very intimately connected with emaciation as it occurs in this malady, is a certain degree of anemia, the combined influence of which is often very readily seen in the countenance. Thus the nose becomes sharp and drawn; the cheeks are prominent and red,—and appear redder by contrast with the surrounding paleness; the conjunctiva of the eye is of a shining white, or with a shade of pearl-blue; the cheeks are hollow; the lips are retracted, and seem moulded into a bitter smile. This peculiar condition of the physiognomy belongs mostly to an advanced stage of the disease; it is very rarely seen at the commencement, and then only in subjects who are naturally very spare in flesh.

It has been observed that as the pulmonary lesion advances, the emaciation increases until it reaches a very extreme degree. Some writer has remarked, that there is no disease in which it is so great as this. It is always very strongly marked in the adipose cellular membrane and muscular tissues; indeed, every organ of the body appears to emaciate, excepting the liver

and heart, and these are often found much smaller than natural. The brain, nerves, genital organs, spleen, pancreas and other glands, although they exhibit no very marked signs of emaciation; yet if carefully weighed they will generally fail to come up to the standard of normal vitality. The blood vessels usually appear small, but this, no doubt, is owing to their having been accustomed to carry only a small quantity of fluid, in consequence of the wasting nature of the disorder, for there cannot be the least doubt but the blood also participates in the general emaciation, and its quantity is very much less than that in health. The emaciation, however, from phthisis pulmonalis, is not only a diminution of all the fluids of the body, but an actual loss of structure by which its weight is very much reduced. When it reaches its extreme degree, death may be looked for at any moment. The utmost reduction in weight which an adult body is capable of enduring, may be placed at sixty-five pounds, when it reaches this point, the light of life flickers very feebly in its torch; the slightest breath may extinguish it forever.

But we should remember, that emaciation is not always a progressive symptom in pulmonary tuberculosis. In some of the more chronic forms of the malady, patients will sometimes hold their flesh until almost the very last. Then again they will for a time lose it very rapidly, and regain it nearly as quick. I had a very striking example of this kind six years since. The patient was a woman 36 years of age, the mother of three children. In health her common weight was 135. After suffering four months with phthisis she lost 25 pounds. In the succeeding four months she gained 22 pounds. Thus she continued to gain and lose flesh for more than two years, before she finally succumbed to the disease. I have on more than one occasion been astonished, at the rapidity

with which patients of this class will sometimes emaciate. I had a young woman recently under my care, who had a small tubercular cavity in the superior lobe of the left lung. During a period of three months she lost 15 pounds in weight, in as many months under the use of cod-liver oil, quinia, and iron, she regained it, and we began to entertain hopes of her ultimate recovery; but suddenly, without any apparent augmentation of her pulmonary disorder, she commenced to emaciate, and that so rapidly, that in ten days she was the merest shadow of herself, and in a few more, she quietly passed beyond the bounds of time, to enjoy the felicities of an endless life, in the paradise of God on high.

It has often been a question with some, whether phthisical patients ever entirely regain their original weight, that is, that which they had before they were attacked with the pulmonary disease. In my observation I have seen three cases, wherein the patients' weight was somewhat increased, while in many others it never attained its normal standard. But some may be ready to ask, what is an individual's normal standard of weight? In the present state of our knowledge this question cannot be positively answered, but we think we have a rule which should govern in the case; one that is sufficient for all practical purposes, namely, "That the physiological weight is regulated by the height of the individual." Dr. Hutchinson originated this rule, and according to his observation a person that is five feet high should weigh 120 pounds; one at five feet four inches, 140 pounds; at five feet eight inches, 160 pounds; and at six feet, 180 pounds; thus calculating an addition of about five pounds weight for every additional inch in height.

"It is scarcely possible," says Dr. Lawson, "to make a rule so mechanical as the above applicable to the varying state of the human organization, and especially in the early stage of phthisis; when the changes are often so very slight; but in the absence of more positive data; it may be well to avail ourselves of every means which comes within the range of probability, or which is capable, even with considerable variations, of general application. In summing up the subject, Dr. Hutchinson states a more general rule, which is of especial and easy application, and may be made available when the patient's weight has not been previously known. In two thousand nine hundred and seventy-six healthy males he found the average weight to be one hundred and fifty-five pounds; while in seven hundred and ten cases of tubercular disease it was reduced to one hundred

and eleven pounds in males, and one hundred and four in females. These facts, however, are more important in their general than special application, for while they clearly indicate the progressive diminution of weight in tuberculosis, each case, nevertheless, must rest on its own peculiarities."^{*}

In referring to this rule of Dr. Hutchinson's, Dr. Thompson says,

"This calculation you will find sufficiently near the fact for ordinary purposes. There are, however, remarkable exceptions to any general law in reference to such standards; great deviations in this respect are consistent with health. One of the most striking examples is that of Smith, the pedestrian, who at the age of about forty, with a height of five feet five inches, weighs only 102 pounds, instead of the average of 142 as registered by Dr. Hutchinson. Nevertheless, Smith may be adduced as an example of a healthy, energetic man. His stride is four feet two inches to four feet four inches, and he has been known to walk twenty miles in two minutes less than three hours."[†]

It may be set down as a general rule, that all temporary changes in the weight of phthisical subjects is indicative of activity or indolence of the tubercular disease in the lungs. I am free, however, to admit that other causes besides this may induce emaciation, particularly diarrhoea and loss of appetite. On the other hand we occasionally see individuals gain weight under favorable circumstances, particularly such as improve the functions of nutrition, while the pulmonary malady loses nothing of its activity. "I have," says Dr. Morton, "known several patients with tubercular abscesses to retain their full habit almost unimpaired; among the most remarkable of these was the late high constable G. of this city, a man of such gigantic frame and general obesity, that nothing but the unequivocal evidence of the stethoscope, convinced me of his actual condition. A few days before his death, I applied the instrument, and detected a large abscess just beneath the clavicle of the right side. The subsequent autopsy verified this observation, and showed the lung of the same side to contain myriads of tubercles in every stage of development. The left lung was also tuberculous, but much less advanced in the disease. Yet I do not recollect ever to have examined a subject more loaded with fat, which, over the thorax, was an inch in thickness; and although his disease had continued for many months, with almost daily hæmoptysis during the latter part of the time, there was very little obvious emaciation."[‡]

Loss of strength usually accompanies emacia-

^{*} Lawson's Phthisis Pulmonalis, p. 331.

[†] Thompson's Lectures on Consumption, p. 167.

[‡] Morton's Illustrated Consumption, p. 119.

tion, and when a person having a hereditary predisposition, comes to us complaining of a loss of strength, flabby muscles, hurried breathing and pulse, loss of flesh, and Thompson's gingival margin, we are prepared to pronounce the existence of pulmonary tuberculosis, although all the physical signs of the disease may be absent. In determining this symptom of emaciation, we are cautioned not to trust to the patient's statements on the subject. We should examine the body, especially the arms, and see if the skin is more loose than it should be, or trust to a pair of accurate scales. Where my tubercular patients are able to be up and around, I generally have them weighed every fifteen days, and mark their weight very particularly, and in this way I can tell with considerable certainty whether the disease is progressing or receding. When in spite of judicious treatment the patient continues to emaciate, we regard it a very unfavorable sign, the disease will unquestionably prove fatal. But on the other hand, when a patient gradually regains his flesh and strength, we may look upon it as a favorable omen, and may prognosticate a partial restoration to health.

ON THE TREATMENT OF FRACTURES.

BY JOHN SWINBURNE, M. D.

Of Albany, N. Y.

Fig. 1 represents a limb treated by extension without splints.

Fig. 2 represents the principle of the treatment of a femur by a Liston splint; a tibia treated by my apparatus; a humerus treated by any of the above-named appliances; also the appliance for Colles' fracture.

I think fig. 2 fully demonstrates where the necessity for the support by adhesive plaster exists.

While in fig. 1, simple extension, without splints, the limb requires no lateral support; per contra, when the extension is made outside of the long axis of the bone, and by the side of the limb, that the limb must be fastened to that line.

In fractures of the inferior extremities, the patient, of necessity, is obliged to keep his bed, and hence there is less demand for comely appliances than in cases of fracture of the arm or forearm. In fracture of the femur, I use simply extension and counter-extension *without splints*, and in the leg I sometimes do the same, making

Fig. 1.

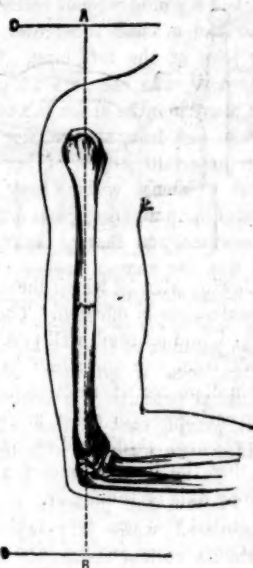


Fig. 1.—a, b, Line of extension; a, counter-extension; b, extension; c, head of bed; d, foot of bed.

Fig. 2.

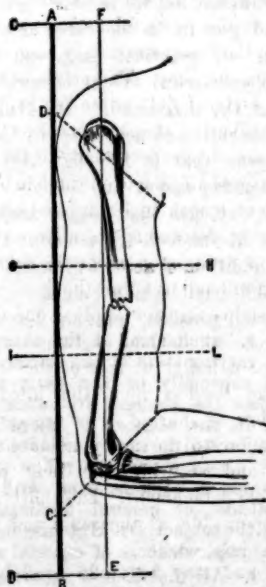
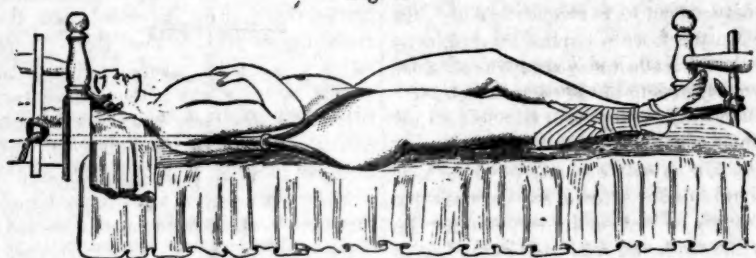


Fig. 2.—a, b, Splint through which extension is made; a, counter-extension; b, extension; c, hole in splint through which extension is made; d, same for counter-extension; e and f, line showing the distortion dependent upon the distance at which it is made from the long axis of the bone; g, h, i, j represents the position for plaster in this fracture.

Fig. 3.



use of the following plan by which the extension and counter-extension is effected. The patient is placed in bed, and a broad, well-padded perineal belt, made from one and a half to two and a half inches in diameter where it comes in contact with the perineum, (in order more fully to equalize the pressure) is adjusted as indicated in the plate, so that the line of extension shall be through the long axis of the femur.

It may be stated that one important object of extension, not mentioned before, is to overcome the otherwise distorting influence of the adductor muscles.

This perineal belt (Fig. 3) is secured to the head of the bedstead, and no splint at all is made use of, as the powerful muscles and fascia that envelope the femur are amply competent to support and fix the bone. The pelvis being thus fixed by the perineal belt, extension is obtained by means of adhesive strips secured to the leg. The plasters are cut proportionally to the size of the limb, from one-half inch to one inch in breadth, and of sufficient length to be applied along the outside of the leg, descending spirally, protruding so as to form a strong loop under the sole of the foot, and then extending up on the inside of the leg. These strips are not applied one directly over the other, but at small distances apart so as to embrace a larger surface of the leg, thus equalizing the tension upon the integument. Then a number of shorter strips are applied in a manner similar to the many tailed bandage, surrounding and securing the long plasters against possible detachment. The shorter strips are not indispensable, as the same end may be attained by a simple roller.

Fig. 1 and 2. All that is now necessary is to pass a strong cord through the loop of plasters, and secure it to the foot of the bedstead. The simplicity of this method is a strong recommendation. There are many occasions when a Liston splint, or any other, can be obtained only

with difficulty; for the treatment by this method nothing is required but ordinary adhesive plaster, which can be obtained very readily; and an old sheet or rope will furnish the remaining complement of apparatus.

The patient can move about in the bed as much as is necessary with greater freedom than when embarrassed by a long splint, and with really less danger of displacement. The seat of fracture can be examined at any moment without having a long bandage to unroll, and wet cloths or other local applications can be used, with as great facility as if the limb were well. The advantages of this method of extension are best manifested in the case of compound fractures; the wound of the muscles and integument is as perfectly accessible as if it were not complicated with a fracture. Perfect cleanliness may be preserved, which is an important consideration, and which it is impossible to obtain when the splint and bandage are used, without much trouble both to the surgeon and patient.

The limb can be measured as often as is desired, and the amount of extension regulated accordingly, with scarcely any trouble, by merely tightening the cord which secures the foot to the end of the bedstead. The circulation is not interfered with, as is often the case when the splint and roller is used; especially when not rightly applied; and, what is to be considered of great importance, the patient is far more comfortable than when trammelled by the usual dressings.

There is no danger of sloughing of the heel or malleolus, a complication by no means seldom met with under the usual treatment, because here there need be no pressure upon the prominent bony projections, either from the bed or the dressings; and with regard to the perineal belt, the chances of excoriation are not greater than when the long splint is applied. In fact, the line of traction in the latter case being more oblique,

has greater tendency to press the upper part of the thigh outward, and is consequently more painful than when the force is applied more directly to the pelvis, which effect may always be obtained by a proper adjustment of the perineal belt.

I have lately treated a patient having delirium tremens which lasted several days, for fracture of the femur. Union was not interfered with or materially retarded. After a few days the patient can sit up in bed or lift his hips for the calls of nature, with impunity and without apparent injury. He can roll from side to side, or even sit up, and thereby relieve the tedium of confinement.

One other, and not the least advantage, is, that in this form of treatment there is no agglutination of the muscles to the bone, or each other, and consequently no stiffening of the limb from that source; and as soon as the bone is strong enough to bear the weight of the patient, the muscles are ready to do their part in the locomotion.

One objection, and by the way the only one which possesses a show of validity, has been made, that the foot is liable to evert or invert; but a single moment's reflection will satisfy any one that no great ingenuity is required to avoid this—a bag of sand or bran on either side of the foot, or a strip of plaster, or of cloth, any of these simple means can be so employed as to maintain the foot in a proper position.

The fact to be dwelt on is, that but little extension is necessary during the first stage of treatment. In order to prevent perineal excoriations, and accustom the patient to the necessary pressure when union is taking place, little more is essential, at first, than what is required to overcome spasmodic muscular contraction, and displacement of the fractured ends. When the process of reparation has been thoroughly begun, even after the provisional callus has been thrown out, or at all events has begun to form, say a period of fifteen days, there is time enough to use extension for the purpose of acquiring the necessary length of the limb. In this way the patient has an opportunity of becoming accustomed to the confinement, and the parts where the pressure falls become inured and hardened, and thus better prepared for the necessary extending force.

The efficacy of this treatment, like that of many and all others, is to be tested by its practical results. So far as an experience of about

thirteen years, which, it is granted, is only a limited time, can be depended upon, there is no method more reliable than this. There is none under which more favorable results have proceeded, none in which there have been fewer failures (in this there have been no unfavorable results) considering the different varieties of fractures to which it is applicable, and in which it has been used; and also considering the circumstances which have often attended, and of course complicated this as all other methods, it has been eminently successful, and has been exclusively used in private practice with uniform satisfaction. No written histories have been kept of the majority of these cases, except facts obtained from note-books, but the results have been such as to warrant its indiscriminate use.

By this method there have been treated forty cases, twelve of which were hospital, and twenty-eight private patients. Of the latter twelve were intra-capsular. (For cases see *MEDICAL AND SURGICAL REPORTER*, Vol. V., page 539.)

MEDICAL SOCIETIES.

N. Y. ACADEMY OF MEDICINE, }
October 2d, 1862. }

ALBUMINURIA.

Continued from Vol. VIII, p. 298.

PROF. AUSTIN FLINT, on the Causation and Pathology of Albuminuria. Dr. Flint proposed to give succinctly his own views as to the present state of our knowledge regarding this subject.

1st. What is the scope of the term Albuminuria? At the time of Bright's discovery, and some time afterward, it was supposed that albumen in the urine was diagnostic of disease of the kidney, but now it is found in various other affections. The quantity of albumen in the urine is small, as an actual symptom, and often transient. The present definition of albuminuria is to be limited to cases in which, from the quantity and continuance of albumen, certain morbid conditions of the kidney are indicated.

2d. What are the pathological conditions of the kidney in Bright's disease?

These have been so fully presented by Prof. Clark, and especially the microscopic appearances, that it is not proper for me to dwell upon them here; they present a good deal of contrariety if not confusion. Bright divides the disease into three forms; Rokitsanski into as many as eight varieties, based upon the gross appearance of the kidney. Dr. Geo. Johnson makes five. The important point to decide is this: What are the immediate pathological effects? They are divided into two classes,

1st. An interference with the secretive function.

2d. Interference with the circulation.

Interference with secretion is produced—

1st. By mechanical obstructions; as by granular matter, fat, etc.

2d. By disintegration and destruction of secreting tissue—a loss of epithelium.

Interference with circulation is produced

1st. By pressure of these same morbid bodies upon the renal veins, giving rise to congestion;

2d. Congestion as a consequence of impaired secretory function. This is a law of pathology, as illustrated in congestion of the lung following pneumonia. Thus arise pathological effects of pathological conditions, as uræmia, an effect of non secretion of urea, which is an effect of interruption of the secretory function; another effect is the presence of albumen.

Are the different morbid conditions of the kidney different stages of one condition of the kidney, or are they different and distinct affections? Many, if not most pathologists regard them as the same affection; thus they suppose the small kidney necessarily implies the previous existence of the large kidney. My own opinion is that this is not correct. If the small kidney be a more advanced stage of the large kidney, we ought to have the same symptomatic symptoms as of the large kidney, but it is not so. Again we meet with patients who have suffered with albuminuria for a great length of time, who yet die with the large kidney.

The acute and chronic conditions, present marked and peculiar characteristics. In acute cases, the patient generally recovers; in chronic cases the patient dies; again the pathological lesions in the acute and chronic conditions are strongly different; not less so than between capillary bronchitis and pneumonia. My opinion is, therefore, that albuminuria represents these different diseases.

1st. Acute albuminuria.

2d. Chronic, without contraction of kidney.

3d. Chronic, with contraction of kidney.

Cases of acute albuminuria are found in scarlatina; the dropsy is marked; urine scanty; there is often hæmaturia; sediment containing casts; albumen very abundant, proving fatal only in some accidental cases, recovery ought always to be expected, other circumstances favoring.

In the chronic form without contraction, we have dropsy from the commencement; casts are present, either granular or fatty; it is always fatal by uræmia or asthenia; nausea and vomiting are often present.

Chronic albuminuria with contraction, is more insidious; dropsy is scanty or wanting; albumen scanty or wanting; uræmia or acute inflammation carries off the patient; the casts are granular, and many of them of large size, $\frac{1}{8}$ to $\frac{1}{4}$ in. in diameter. Johnson considers the casts important as indicating the disease when albumen is wanting; oily casts denoting oil, granular, denoting partial destruction of epithelium. If this view be correct, we are greatly indebted to the

microscope, which is to the kidney, as the stethoscope to the heart and lungs.

The appearances composing morbid anatomy are only results of pathological processes. What are the pathological processes in the kidney? According to Christison the pathological process is congestion, but there is much doubt of the correctness of the theory. Bright's disease of the kidney does not result when congestion has been known to exist for a great length of time; valvular disease of the heart, which leads to congestion, does not lead to disease of the kidney. Johnson supposes albuminuria to be a kind of renal bronchitis and looks upon the casts as a species of expectoration.

Morbid action of the ganglionic system of nerves has been suggested as a cause of congestion, but in the majority of cases there are no local affections to produce morbid ganglionic action.

There is not sufficient attention paid to the law of parallelism—symmetrical disease; both kidneys are affected to the same degree and in the same manner. Such affections according to modern pathologists, depend upon some kind of blood change.

Relations of symptomatic events of clinical history to the pathological effects. Secretion of albumen and non-secretion of urine.

1st. The relation of non-secretion of albumen to dropsy—the diminished density of blood favors dropsy.

2d. Diminution of albumen in the blood produces difficulty of circulation; dropsy is proportioned to diminution of albumen. Loss of albumen accounts for anemia; withdrawal of albumen leads to withdrawal of the red corpuscles of the blood.

3d. Relation of retention of urea to uræmia; vomiting and nausea are efforts of nature to eliminate urea, which irritates the stomach and intestines:—in one case of removal of the kidneys, urea itself was found in the intestines. It is the cause of acute inflammation and of coma.

In acute albuminuria as in scarlatina, we have bronchitis.

In chronic albuminuria, albumen is formed more slowly.

There is no ground to suppose there is any connection between albuminuria and an anterior local affection.

Age.—In 52 cases, excluding cases of scarlatina, there were none under 10 years of age, and none over 70 years; the tendency of the disease is toward the middle period of life, from 20 to 40.

Sex.—It is much more frequent in males than in females.

Intemperance.—In 27 cases in hospital practice, 2 were of temperate habits; 25 not temperate. Of 10 cases in private practice, 9 were intemperate, 1 was temperate.

Have not observed the disease in connection with gout.

Does albuminuria produce cardiac disease or vice versa? There is probably no causative relation either way. In a great majority of

cases of heart disease, albuminuria does not exist except incidentally, as has been stated in my book on cardiac disease. In 14 fatal cases of albuminuria in hospital practice, there was no heart disease in 7. Of 10 cases in private practice not fatal, there were no signs of cardiac disease in 9. In view of these facts, we have no ground to suppose there is any causative relation between the two affections.

Of 100 cases given by Bright, 49 are claimed to have had cardiac disease, but this number should be very much reduced.

Of thirty cases mentioned by Prof. Clark, cardiac disease existed in only 3.

Effects of Albuminuria upon Vision.—Dr. NOYES remarked that the loss of vision in consequence of albuminuria is by no means infrequent. Of 10 cases recorded by Bright, five had more or less impairment of sight. It was formerly supposed that the disturbance of vision was due to cerebral trouble, but later investigations have shown that the cause exists in the eye—an affection of the retina. Albuminuria can be detected by examining the retina with the ophthalmoscope. In chronic forms of blindness, the result of albuminuria, recovery is slow and protracted, but in cases where the vision becomes impaired from uræmic convulsions, the brain being chiefly affected, recovery follows within forty-eight hours. The sole item to be borne in mind in these cases, as scarlatina and pregnancy, is uræmic poison; yet it does not follow that convulsions must ensue. A case is mentioned as having occurred in Berlin, of metastatic inflammation, where loss of sight in both eyes was produced by plugging up the capillary vessels of the choroid with clots. Loss of sight may sometimes come on very suddenly, in which case we shall have cloudy visions; *muscæ volitantes*; the pupils will not be contracted. There is nothing now known of this affection, except by the ophthalmoscope. The haziness gradually overspreads the whole retina, and soon passing away will not be seen unless sought for at the proper time; the blood vessels become reddened and conspicuous; the edge of the retina dim, and dense white spots remain, which are characteristic of Bright's disease of the kidney; they are bright and glistening, sometimes appearing in clusters resembling the Pleiades. In retinitis fully developed, in place of the white disk, the rim entirely disappears and extraordinarily developed capillary blood vessels may be seen spreading over the margin of the optic nerve joining the sclerótica. This intense degree of retinitis does not often make its appearance.

The haziness is due to serous infiltration—ordinarily the white spots are evidence of thickening; sometimes by globules of fat; sometimes by morbid lymph in scales or fibres. A large increase of fibrous tissue interferes with sight. The ganglionic cells of the retina are subject to fatty degeneration, but the important structures seldom undergo any change—when the diseased portions are removed, vision is regained. Discoloration of the pigment cells of the choroid, indicates development of fibrous tissue.

Dr. GRISCOM inquired if the white spots above alluded to as appearing on the retina are characteristic of albuminuria.

Dr. NOYES, replied, that they are. There is however a class of white spots which appear in syphilitic retinitis, resembling those of albuminuria, and can be distinguished from them by their clearly defined and regular margin, while those of albuminuria are gradually shaded off into an irregular margin of detached points. In the former case the spots are formed by a plastic exudation; in the latter case by molecular degeneration, and consequently they present corresponding differences.

[To be continued.]

ILLUSTRATIONS OF HOSPITAL PRACTICE.

COLLEGE OF PHYSICIANS AND SURGEONS,
October 8th, 1862.

CLINIC OF PROF. WM. DETMOLD.

SYPHILITIC ULCERS.

These you will observe appear on different parts of this body. The patient was here a week ago, when hyd. protiodid. was ordered internally, with no application externally, with the view of testing the diagnosis, as no primary sores were acknowledged—a cure is progressing rapidly.

LUPUS

On the leg. Apply a wash of cupri sulph., and administer Fowler's solution internally.

CONDYLOMATA.

The Mucous Tubercles of modern writers. These are around the anus, and are of six months standing—from the nature of the disease, the age (18 years) of the patient, and history of the case, there can be no doubt of a syphilitic origin, although the patient stoutly denies ever having had any primary ulcer. Apply liq. ferri perchlor. freely with a sponge every other day.

SYPHILITIC ULCER.

This occurs on the leg. Apply an ointment of hyd. nit. oxyd., ʒi, cum ol. olivæ, fʒj. There is a mistake in the manner of using powerful remedies, instead of beginning gently and increasing gradually as is the custom, they should be applied powerfully at first and afterward diminished if necessary—in this way an impression is made which will not be produced by the other method. This ulcer has been under treatment for over a year without benefit; I shall expect to heal it in a week.

ACNE.

This case was here a week ago. Lac sulphur with benzoin, was ordered, and now the patient is better—had previously attempted various remedies for six years without benefit.

UNIVERSITY MEDICAL COLLEGE, N. Y. }

October 4th, 1862. }

CLINIC OF PROF. ALFRED C. POST, M. D.

TALIPES VARUS.

A child 7 months old, which was operated upon one week ago. After the operation a bandage and gutta-percha splint were applied, and passive motion frequently resorted to. The rest of the child was very much disturbed at first, but has slept well the last two nights. The foot is not yet straight, but there is a very decided improvement, which promises ultimate success. In treating these deformities, the most important thing is to keep up passive motion. The operation will not accomplish all. Passive motion will produce some pain, which is unavoidable. You should make reflection, abduction, and eversion.

SYNOVITIS.

A boy 7 years of age, had Scarlatina about two years ago. Lameness appeared about a year ago, and came on gradually. The fact of the remoteness of the appearance of the swelling from the attack of scarlatina shows that the lameness is independent of scarlatina—the sequelæ of scarlatina seldom appear so long subsequently, although sometimes the exanthematous fevers develop a tendency to strumous disease, which may result as a consequence. Chronic enlargements of the knee-joint present different characteristics, according to the tissue in which the disease commences, whether in the synovial membrane, in the articular extremities of the bones, or in the cartilages. It is rare to meet disease commencing in the spongy extremities of the bones in adults, but it is common in children—disease commencing in the cartilages is the most common in adults, and that commencing in the synovial membrane equally common in either. Disease of the synovial membrane of the knee-joint leads to effusion of fluid and consequent distension of the synovial pouch, above and around the patella, as visible in this case. The patella itself is sometimes elevated. In this case the patella is fixed. Extension cannot be accomplished. Any wound or disease occurring in the knee-joint, demands especial attention to the movements and position of the knee; early extension should be kept up, and if the joint should be immoveable it is better to have the leg flexed to an angle of 10° or 15° from a right line. Nine-tenths of the medical profession are at fault in neglecting the position of the joint, being wholly intent on curing the disease. An ounce of prevention is worth a pound of cure. The patient should be placed in bed, passing the leg over an inclined plane, leaving the joint flexed as before mentioned. Give the patient two grains of the Iodide of Potassium, three times a day. It is well, when the patient can afford it, to have a moveable splint applied.

INFLAMMATORY SWELLING.

This is situated at the anterior part of the wrist, in a female, 18 years of age. Six weeks ago she had a felon on the thumb of the same hand, which discharged spontaneously and healed readily. Swelling ensued which has extended to the wrist—there is a general thickening of all the tissues of the joint, and no tendency to suppuration, but simply inflammation of the fibrous tissues. Give her hyd. chlorid, mit. gr.ij, opii gr. j, daily for twelve days, and apply fomentations of hot whisky and water, with a piece of flannel wrapped around.

INJURY TO ELBOW JOINT,

Caused by falling upon it two months ago: child $6\frac{1}{2}$ years of age—there may be fractures; possibly, it is a mere sprain; the joint is immovable, and the elbow flexed but little from a right line. By applying considerable force, for some time, the professor flexed the elbow bringing the hand to the chin, and suspended the arm in a sling. The elbow joint should be treated in the flexed position, except in fractures of the olecranon process, contrary to the practice with the knee-joint. By wearing the arm in a sling and keeping up passive motion, the child will probably recover the use of its arm.

A swelling on the side of the ankle in a child 2½ years of age, with a discharge of sanious matter, indicating a carious state of the bone; swelling appeared 18 months ago. Give the child tr. ferri iodid., gtt. ij., three times a day.

NEUROMA.

Male, 28 years of age. He complained of pain and stiffness of the elbow for the last three years; there is nothing abnormal about the joint; a small tumor of the inner condyle, upon which the skin moves freely, but which does not seem to move freely over the subjacent tissues, is all that appears. I am not prepared to express a positive opinion, but my first impression is that it is a neuroma, but then we ought to have extreme pain, yet in persons having a great number of neuromæ, there is absence of pain. It has the consistence of a firm fleshy tumor and does not seem to be connected with the joint. From the probable nature of the tumor, I do not think it advisable to remove it. The pain of which the patient complains may be connected with syphilitic disease. Give potassæ iodid. gr. iij., three times a day.

HEMORRHAGE, FROM THE RECTUM.

Male, 27 years of age; for 17 months past, patient has been in the habit of passing about a thimble full of blood, frequently during the day; on examination with the finger, the left side of the rectum from 3 inches above to $1\frac{1}{2}$ inches of the anus is a mass of irregular excrescences like a coxcomb, limited by the median line. Of course this implies a serious form of disease, probably epithelial cancer. The hemorrhage is not enough to be serious to the patient. Apply cold water frequently, and soothing lotions.

THE MEDICAL AND SURGICAL REPORT

PHILADELPHIA, SATURDAY, OCTOBER 11, 1862.

THE AMBULANCE SYSTEM.

We have been disposed to be very patient, and very hopeful in regard to every apparent mismanagement in connection with the existing war. There are many subjects on which it would be the merest presumption in us to venture a judgment, or even, perhaps, an opinion. But there is one evil, and it is an admitted, and a crying evil, which we must say unreservedly, it is high time was corrected. We allude to the bad management in connection with our army ambulance system.

The numerous promises of amendment are evidence that government knows that the evil exists. Why, then, is it not corrected? The Surgeon-General has been urging a reform ever since he has held his office; but some one, either the General-in-chief, or the Secretary of War, seems to stand in the way. Is there nothing that will arouse them from their lethargy? "While Nero fiddles, Rome burns." While the Secretary and the General hesitate and delay, our noble soldiers are dying, horribly dying, on the battle-field, from neglect. We are aware that the chief executive officers of the government are overwhelmed with important and arduous labors. But surely there is little labor that is of greater importance than the care of those who fall wounded on the battle-field. If armies are organized and sent into the field to fight, it is to be expected that there will be wounded men to take care of, and the plainest dictates of humanity suggest that there should be adequate provision made for removing them from the field, and placing them under the care of the surgeon.

Government has provided expensive ambulances, but they are not, we believe, under the control of the surgeons, and are managed so wretchedly, that really they often seem to be of little practical use. Their drivers, and the teamsters generally in the army, seem, from the commencement, to have been a set of outlaws and drunken vagabonds, getters-up-of-panics, and mischief-makers generally. From all accounts, those who drive the ambulances have generally been very unreliable men, whose tender mercies have been of the most cruel kind. We have been indisposed to believe the revolting scenes described by some newspaper correspondents,

but they are so often reiterated and so well attested that we are forced to believe them.*

There is one aspect of the case that we have not been able to comprehend. We had always supposed that every army and all connected with it, every branch of every service, was under strict military discipline, and that the *commanding general* was responsible for the government of the whole. If it is not so, it certainly ought to be, and it should be his business to see that so important a branch of his service as the ambulance corps is thoroughly and efficiently organized, and that those connected with it pay some regard to their duties. And we are compelled, in this view, to hold the commander of an army directly responsible for any serious mismanagement in this service.

We are told, over and over again, that all this "is to be changed," that the ambulance corps is "being reorganized on an entirely new plan," etc., etc. In Heaven's name let it be done, and that speedily, before another great battle is fought. It is surprising that the Surgeon-General should have been interfered with at all in this matter. Government should give him a *carte blanche* to organize this corps as he pleases, and it should be entirely under his control and that of his subordinates, subject only to ordinary military rule. How is it that the Quartermaster's Department has had any thing at all to do with this branch of the service? It seems to us to be entirely foreign to it in substance and in spirit.

We are glad, however, to see indications of improvement in this matter. We are told that the Surgeon-General is at last permitted to make salutary changes that he has long desired to make—that an ambulance corps is being organized, which will dispense with the miserable crew who have brought so much disgrace on this important branch of the army service. It is stated that General McClellan has organized an ambulance corps for each division of the army under his immediate command. Each brigade is to have a captain and a second lieutenant, and each regiment a serjeant. They are to have the control of all ambulances and transport cars. To make this organization complete, these officers should be under the direction of the surgeons, and *not* of the quartermasters. The Medical Department of the army should be made as independent as possible.

Time is accomplishing much. We accept

* In this connection read a communication on a subsequent page, from Dr. Bowditch, of Boston.

what has been done with due gratitude, and trust that the wise counsels of our indefatigable Surgeon-General will no longer pass unheeded, but that under his guiding hand our armies will soon possess an ambulance corps that will be a credit to them, and to the nation.

THE U. S. PHARMACOPŒIA.

When will this important national work which, many physicians and pharmacutists anticipate with so much interest, make its appearance? We have had many inquiries regarding it from physicians and apothecaries in both public and private practice. Nearly two years and six months have elapsed since the Convention of Delegates from the Medical and Pharmaceutical Colleges convened in Washington, to go through the formalities necessary to give to this standard its national authority. Previous to that Convention the labors of the College of Physicians and College of Pharmacy of Philadelphia, and of several learned bodies in other cities, had been bestowed upon the revision, and the required amendments had been pretty thoroughly discussed. We know that it is a work requiring mature deliberation and great care to render it as nearly as possible a perfect standard, but confess our inability to appreciate the necessity for prolonging the period of uncertainty in regard to the official process, which always intervenes between the discussion of proposed amendments and the final announcement of those adopted by the Committee. This inconvenience is especially felt by the professors and classes in the numerous medical and pharmaceutical schools, which are just commencing their winter sessions, and we had looked for the issue of the revised pharmacopœia, at least in time for use in the courses of instruction about being inaugurated.

THE ST. LOUIS MEDICAL COLLEGE.

In the *REPORTER* for September 6th, we stated that no lectures were delivered in the St. Louis Medical Colleges last winter, and expressed a doubt whether any would be given the coming winter. We learn that lectures were given in the St. Louis Medical College last winter, and are glad to announce that they will be delivered as usual this winter, and that the prospects of a good class are encouraging. Among the professors in this college, are the well-known names of Pope, Linton, Pallen, and Watters. It has an able faculty, and its position is such as should command a large patronage.

THE MEDICAL DEPARTMENT OF THE WEST.

The recent battles at Corinth have called forth all the energies and resources of the Medical Department of the West. The Assistant-Surgeon-General, with his accustomed foresight, had, in anticipation of a speedy engagement between the Union and rebel forces, taken such precautionary measures as enabled him to render ample aid, both medical and otherwise, so eminently necessary for the well-being and comfort of the wounded, who numbered over two thousand. In addition to the medical staff already in the field, a large force of surgeons, fully adequate for the emergency, were despatched to the scene of the recontaction. Surgeon H. P. Stearns, U. S. Vol's., and Assistant-Surgeon H. M. Sprague, U. S. A., were ordered to Cairo, with instructions to give special attention to the transportation of the wounded, and to furnishing all requisite supplies. Hospital steamboats, fully equipped, were sent to bring to St. Louis, and to other points on the Mississippi, as might be deemed expedient, the wounded and such sick as could, with safety, travel, by which means the hospitals, in the vicinity of the battle-field, previously occupied by the sick and convalescing, were so relieved as to accommodate those whose wounds would not admit of their removal.

In St. Louis, Assistant-Surgeon B. E. Fryer, U. S. A., was entrusted by the Assistant-Surgeon-General with the superintendence of the necessary preparations for the reception of the wounded at the various hospitals in and near the city.

Surgeon M. Mills, U. S. A., the Medical Director of the Department of Missouri, worked unceasingly, exhibiting in a marked degree his fitness for the position he has attained.

The prompt manner in which medical and surgical relief has been furnished on all occasions by the Medical Department of the West, since its establishment, is not one of the least proofs of its utility, both to the service and to the cause of humanity, and reflects the highest credit upon its chief, Colonel Robert C. Wood, U. S. A.

Another Military Hospital is to be erected in this city on the Hunting Park Course, corner of Old York Road and Nicetown Lane.

Central Park Hospital, New York.—Dr. F. H. Hamilton, Surgeon of Volunteers, has been assigned to the Central Park Hospital, New York. An excellent appointment.

EDITORIAL NOTES AND COMMENTS.

Resignation of Surgeon-General Smith.—Last week we announced the resignation of Dr. Henry H. Smith, of this city, as Surgeon-General of Pennsylvania. Since then, the following correspondence has been published. We can do no less than say, that the compliments paid by Gov. Curtin to Dr. Smith's "science, ability, laborious activity, and administrative capacity," are fully deserved. Dr. Smith has been untiring in his devotion to the interests of the sick and wounded of the Pennsylvania troops, and to him, as well as to Gov. Curtin, they are indebted for the complete arrangements made for their welfare, surpassing, we believe, those of any other State. Dr. Smith resumes the duties of his private practice in this city, and of Professor of Surgery in the University of Pennsylvania:

SURGEON-GENERAL'S OFFICE,
STATE OF PENNSYLVANIA,
HARRISBURG, October 1, 1862. }

GOVERNOR:—After seventeen months of active service in the "Hospital Department" of the State, I find urgent private interests demanding my attention.

I therefore respectfully tender you my resignation as Surgeon-General of Pennsylvania, and embrace this opportunity to express my high appreciation of your untiring interest in the welfare of the sick and wounded of our Pennsylvania volunteers.

Your judicious plans to ameliorate their sufferings, have opened to me a sphere of usefulness, in which I have felt it an high honor to have been permitted to co-operate.

With sentiments of respectful esteem and consideration, I remain

Your obedient servant,

HENRY H. SMITH.

To His Excellency, A. G. CURTIN, Governor of Pennsylvania.

PENNSYLVANIA EXECUTIVE CHAMBER, }
HARRISBURG, PA., Oct. 10, 1862. }

SIR:—I have hesitated in regard to the acceptance of your resignation of the date of the 1st instant, of your position as Surgeon-General of Pennsylvania, although fully sensible of the private inconvenience and loss which the office has caused you. Having now an opportunity of securing the services of a gentleman of high character and qualifications, I have appointed him as your successor.

It is impossible to over-estimate the benefits which our sick and wounded men have derived from your science, ability, laborious activity, and administrative capacity.

You have organized a very difficult department so efficiently, that it will be comparatively

an easy task to continue its operations. The zeal with which you have repaired to remote scenes of battle and pestilence, and your untiring efforts to minister to the safety and comfort of our men, will not soon be forgotten by the people of the Commonwealth. In assenting to your wish to retire, I must give you my thanks for the services which you have rendered, and repeat my regret at the severance of our official connection.

Very respectfully,

Your obed't servant,

A. G. CURTIN.

H. H. SMITH, M. D., Phila.

Interesting Surgical Notes on the War.—Next week we shall begin the publication of a series of interesting papers, entitled "*Off-hand Sketches of an Army Surgeon's Experience during the Great Rebellion*," by a Surgeon who has had a great deal of practical experience in the field, his brigade and regiment having been in nearly all the principal engagements in the Army of the Potomac. We trust these papers will elicit notes of the experience and observation of other surgeons in the army.

The Military Hospitals of Philadelphia.—Surgeon-General Hammond made an official visit of inspection to the military hospitals of this city last week, and is reported to have been well pleased with their management. We have had frequent occasion to commend the general management of these hospitals, and we are glad that their condition is so satisfactory to the Government.

Epidemic Hysteria.—A recent English paper reports a case of epidemic hysteria occurring among some factory girls.

Upward of three hundred girls were employed in sewing, and one or two of them were subject to fits. One afternoon recently, everything was proceeding in the usual manner, when suddenly one of the girls was prostrated by a fit. There was considerable alarm created by this circumstance, and almost instantly another girl was attacked, and then another, and another, until quite a panic prevailed; altogether, nineteen girls becoming affected in less than an hour.

A few years ago, we witnessed a similar epidemic among some negroes. In a house occupied by several negro families, a stout boy fancied that poison had been put into some cake that he had eaten. He was forthwith attacked with severe cramps, then with violent convulsions, of a decided "hysterical" character. A girl that he

had been "visiting," who had eaten of the same cake, soon followed suit, and others who had eaten, or fancied they had eaten of it, did the same, until a scene was enacted that excited the whole town for a time. We can compare it to nothing better than the "flapping" of a haul of large fish, when thrown from the water on the beach. Those who have visited shad or herring fisheries will understand what we mean.

An isolated case occurred in another part of the town, in the person of a stout wench, who had been at the aforesaid house, and who fancied she had eaten of the "poisoned cake." Valerian, opium, and discipline were the remedies resorted to. The convulsions, which in some of the cases were of the most violent kind, gradually subsided.

Medical Department of the West.—We give below the names, and present locations, of the Medical Directors in the above Department:

SURGEON W. J. SLOAN, U. S. A., Department of the Northwest, St. Paul, Minnesota.

SURGEON MADISON MILLS, U. S. A., Department of Missouri, St. Louis, Missouri.

SURGEON H. R. WIRTZ, U. S. A., Army of the Tennessee, Head-Quarters of Major-General Grant, Jackson, Tennessee.

SURGEON B. J. D. IRWIN, U. S. A., Army of the Southwest, Helena, Arkansas.

SURGEON L. H. HOLDEN, U. S. A., Department of the Ohio, Cincinnati, Ohio.

SURGEON R. MURRAY, U. S. A., Army of the Ohio, Head-Quarters of Major-General Buell, Louisville, Kentucky.

Chestnut Hill Hospital Philadelphia.—Dr. Joseph Hopkinson of this city, whose management of the Twenty-second and South street Hospital has been so highly recommended, has been selected by the Surgeon General to take charge of the Chestnut Hill General Hospital, now in course of erection. This will contain over three thousand beds, and will be the largest in the world.

The Richmond Hospitals.—From a report presented in the Confederate Senate, yesterday, (Sept. 22,) it appears that the whole number of patients (soldiers) admitted into the various hospitals in and around Richmond, from the date of their organization to the present time, was 99,508, of whom 9774 have been furloughed, and 7603 have died. The rest, it is presumed, have recovered and been discharged, except those remaining in the hospitals.—*Richmond Whig.*

CORRESPONDENCE.

DOMESTIC CORRESPONDENCE.

Treatment of Fractures of the Long Bones by Simple Extension.

MESSRS. BUTLER AND LEVIS:—

In the MEDICAL AND SURGICAL REPORTER of April 26th, I find a review by O. C. Gibbs, M.D., of an article published in the *American Medical Times*, also in the transactions of the Medical Society of the State of New York, for 1861, entitled "Treatment of Fractures of the Long Bones by Simple Extension," by John Swinburne, M.D., Albany, N. Y.

In this review Dr. Gibbs states something which is untrue, and others which evidently display his want of familiarity with the merits of the paper, and since I am one of the many who have enjoyed the privilege of witnessing the satisfactory results of this mode of treatment, I claim the privilege of expressing myself fully, to the end that the profession may judge for themselves of its merits. I will also add some portion of his paper which can be referred to in illustration of the points.

Doctor Swinburne claims nothing for the paper except its universal adaptability to all fractures; its cheapness; readiness of adaptation, &c. If the method possesses all the advantages which he claims for it (and I think it does) we have, I trust, the grand desideratum for the treatment of all fractures.* In this review Dr. Gibbs says, "While we deny that Dr. Swinburne's treatment of fractures is without splints, we are willing to confess that aside from the leg, his illustrated treatment we regard as the very best known." We in Albany who are in the habit of inspecting cases, and treating fractured legs after this plan, are "willing to confess" that his method of treatment of fractures of the thigh and leg "as the very best known" since the results are so perfect that after the lapse of a few weeks it would be difficult to say which was the broken limb.

The following very remarkable statement is not unworthy of notice since Dr. Gibbs says Dr. Swinburne ignores one of the cardinal principles contained in his paper when he says, "To say that he (Dr. Swinburne) treats fractures without splints is to say what is not true; that he altogether dispenses with side supports is also untrue." The design of Dr. Swinburne's paper was to show to the profession that "fractures of all the long bones" could be treated without splints—in the common acceptance of the word—with what success we leave for the profession to decide from the inspection of the following diagrams, which illustrate the treatment applicable to all fractures either of the thigh or leg. (See illustrations on pp. 37, 38, of this number.)

In reference to side support Dr. Gibbs makes the following statement, "We do not see how it can be determined whether side support is necessary or not, providing it be always used

* See Fig. 2, in this number, p. 37.

because more convenient." The side support here spoken of is only necessary or convenient where the extension is made as indicated in fig. 1, in contradistinction of fig. 2, while his quotations are from the fractures which are treated according to fig. 2, where the extension is made outside of the long axis of the bone—so that well can he (Dr. Gibbs) say "if in his hands *the bed is the splint* we cannot see how this differs in principle or effect from the common straight splint." I will only refer Dr. Gibbs to figs. 1 and 2, for the elucidation, and in so doing I can conceive he will see that he does not "rightly understand the matter." Then he says, "The patient is confined longer and to a more immovable position than when under the most approved method now in use by the best surgeons." On the contrary broken bones treated by Dr. Swinburne's method result better and with more comfort, and give the patient less annoyance and pain than any other form of dressing with which I am acquainted—in fact the less dressing, the more perfect the result, providing the requisite extension is kept up until union is effected.

We agree with Dr. Gibbs that "the maintenance of extension and inflexible side support is all that is necessary to the successful treatment of fractures," unlike Dr. Gibbs, however, we know from experience that the extension properly applied produces sufficiently the "inflexible side support" by putting the muscles upon the stretch, and thereby obviating the necessity of any foreign substance as "inflexible side support," and as to the "convenience" of "side support," I have only to say that this does not apply to the treatment of fractures where the extension is made through the long axis of the bones,* while side support is only applicable where the extension is made through the medium of a "delicate splint."

While it is *untrue* that "side support" is *always used*, I will go still further and say it need never be "*used*," "because more convenient," unless the extension is made outside the limb.

I will show that the article in the *Medical Times* alluded to by Dr. Gibbs is taken almost verbatim from manuscript presented and read before the State Medical Society as now published in the transactions for 1861, and still more that it is untrue "that Dr. Swinburne often uses two or more splints." (See cuts in transactions, 1861.)

Dr. Gibbs asks, "Are we to believe Dr. Swinburne when he says he has treated fractures thus for thirteen years?" Let us see what Dr. Swinburne does say on this subject, as we feel that the Doctor should stand correct on the record. It will be seen by reference to his published report that the time in which he commenced his treatment of the various fractures varies considerably, that while he has been

treating fractures of the femur 13 years in this way, the time varies as to the others. Now for treatment of fractures of the thigh by simple extension without splints. See *MEDICAL AND SURGICAL REPORTER*, vol. 5, p. 539.

The number of cases treated without splints in the transactions to which Dr. Gibbs refers, is 40, and the experience claimed is a period of 13 years.* The treatment of fracture of the leg was commenced in 1858, by extension through the medium of a splint, while the time at which he commenced his treatment of cases by extension without splints dates from 1861.†

Treatment of fractured humerus by extension through a crutch and arm piece commenced in 1859. Transactions, *Ibid.* p. 138. See diagram.

The treatment of fracture and dislocation of the elbow, &c., commenced by extension in 1859. Transactions, *Ibid.*, also *MEDICAL AND SURGICAL REPORTER*, vol. 3, No. 11, also vol. 7, p. 74.

Treatment of fracture of the fore arm (Colles' &c.) was commenced in 1860. Transactions, p. 147, also *MEDICAL AND SURGICAL REPORTER*, vol. 5, p. 609. See also Prof. Gross' Surgery, last edition.

Now in each of these papers the *reason* is fully given why the extension in any fracture is made through a splint rather than the bed as in the case of the thigh.

Now Dr. Gibbs states, "A few weeks after Dr. Swinburne read his paper before the Medical Society of the State of New York, it was published in the *American Medical Times*," and that these statements "are *slightly different*," and in his subsequent quotations he attempts to show the discrepancy in the statement as published. I deny that there is any discrepancy. That the article in the *Times* is taken from the body of the manuscript almost *verbatim*, not by himself, but by the editors of the *Times*, in proof of which I will only refer Dr. Gibbs for the portion of his quotations from the *Times* as being "*slightly different*" from the transactions on page 132, from which it was quoted verbatim. Then Dr. Gibbs need not claim for Dr. Swinburne the right to change his paper from matters of style, nor need he "deny him the right to change the facts," since all the quotations made by the *Times* can be found in the transactions, on the following pages, 109 to 114 inclusive, 132, 134, 138, 144, 147, 150, 155.‡ So that well can Dr. Gibbs say, "We suppose the *FACTS* of the author's experience were correctly given in the paper as read." And in answer to his inquiry—"Was the first publication (in the *Times*.) a transcript of that (in the transactions.) and published by his consent?" I say, yes! While an examination of the above mentioned pages in the transactions, will attest the truth of the statement that Dr. Swinburne has

* Transactions, Plate 2, fig. 3—also Prof. Gross' Surgery, last edition.

† See Transactions, p. 135.

‡ These selections from the manuscript as read before the Medical Society of New York State, and published in the *American Medical Times*, were made by Dr. Shady, one of its editors, after which the paper was published from the manuscript in the Transactions verbatim.

* Transactions N. Y. State Medical Society, 1861, Plates 1 and 2, figs. 1, 2 and 3.

not changed the "style," nor has he changed the "facts," since the paper was not "revised by him" or any one else, but was, as before stated, quoted almost verbatim. Nor is there any truth in the assertion that "much more is said here (*Times*) in reference to the treatment of various fractures, and the use of splints, which is entirely left out in the paper as it stands in the transactions," since reference to the above mentioned papers in the transactions will show that there was no necessity for the aforesaid inquiry.

Dr. Gibbs states, "We had supposed motion at the point of the fracture, however slight, would delay union, and that extension alone would not necessarily prevent this slight motion." I ask, would splints, as ordinarily applied, "prevent this slight motion?" One would be led to suppose it would, since the Doctor characterized it in opposition to simple extension as an "ingenious splint," "properly adjusted splints," "an appropriate splint," in contradistinction to extension without splints—though he says, "When extension is complete the muscles will, it is true, force the bone into line; and if that extension is maintained, and no other, and opposing forces are brought to bear, the points of fracture will retain their apposition." I would ask, what "opposing forces" can be brought to bear. If they do not effect reduction they certainly could not be "brought to bear," so long as the "extension is complete," and the same is retained.

Though in the next paragraph he repudiates his former statement in the following words, "Let the extension be ever so perfect, the unequal contraction of the muscles, (whether spasmodic or otherwise,) and any lateral force, it seems to us, might accomplish lateral motion—a swaying at the point of fracture that must operate to retard union." For my part I cannot understand how there can be "a swaying at the point of fracture" if the muscles are on the stretch, and the limb is extended normally, hence the muscles which encircle the bone at the seat of fracture become like so many elastic splints, while "experience" demonstrates that to overcome spasm nothing is necessary except putting the muscles forcibly on the stretch, at which time "experience" proves that if the limb is rotated or otherwise moved the "swaying" is not at the seat of fracture but in the joint, so that well may he say that "these theoretical objections of course become null before positive facts of experience," and it does not, of necessity, follow that "the upper portion of the fracture is connected to the body, and must respond more or less to its motion." It is possible it may so respond if treated by an "ingenious splint," where the line of extension is outside of the limb as is demonstrated in fig. 2; while on the other hand it has been demonstrated to a certainty, that the upper portion of the fracture does not "respond" materially to its "motion," see fig. 1, where the extension is made through the long axis of the bone—so that, if the Doctor will but refer to these two diagrams,

and also 3 and 4, the same put in practice, he will see how extension without splints can give better results than "appropriate extension" maintained by aid of "splints!" Any one can see at a glance by reference to these diagrams that Dr. Gibbs would be leading us astray by saying that "extension with the possibility of motion at the point of fracture (is) better than extension without such possibility."

Now in order to effect this "extension without the possibility" of "motion," he would require some more "properly adjusted splint" than I have ever found unless the extension is made as indicated in plates 1 and 2, figs. 1 and 3, so that if there is the possibility of motion at the point of fracture in the figures just alluded to, how much truth would there be in the statement that this "possibility" could not exist in the treatment as indicated by plate 1, fig. 2.

Dr. Gibbs starts out with the statement that "the Doctor (Swinburne) assumes that in treating fractures of all the long bones splints are useless, or even worse than useless, except as a means to maintain extension. This proposition is not so novel as it would first appear. To maintain extension and prevent motion at the seat of fracture are the ends to be secured by means of splints—anything more than this is useless."

Let us see what are the teachings of the profession. Outside of fractured femurs, I think there is little said of extension in the treatment of fractures, and with what faithfulness extension was maintained even in fracture of the femur, I will only refer the reader to Hamilton on dislocation and fractures, for results—which to say the least are not flattering. Now all Surgeons know how easy it is to extend a recently broken thigh, or other limb, to its normal length, and if it is thus retained there would be no shortening.

The general treatment of the leg consisted in some kind of fracture-box in which the limb was confined while little was said of extension—while if (agreeable to the theory of Dr. Gibbs) "an ingenious splint is well applied the patient may be off the bed in two or three weeks." Nor is it true that in fracture "of the leg they need not be confined there at all." As a surgeon, I would like to know something more of this "light ingeniously-devised and well applied splint," which allows a patient with a fractured thigh to "be off the bed in two or three weeks," while in those of the leg "they need not be confined there at all," and although he speaks of this form of "splint-like arrangement," no less than seven times in his review, he does not tell what these "light and appropriate splints" are, by which this "appropriate extension" is kept up.

In the following quotations Dr. Gibbs admits that "he (Dr. Swinburne) presents very clearly the object to be secured by all dressings in case of fracture, and the effect will doubtless be a simpler dressing in all such cases, and better results." Now, if the dressings are "simpler," and the results "better" why this review? Is

it intended to destroy the confidence of the public in a plan of treatment which he (Dr. Gibbs) represents as a "simpler dressing," and the "results better?" Or, is he charmed at his own witticisms? One would be led to think it was the latter since he goes on to say, "there is however no novelty about his principles; extension and immobility we have ever had prominently before us in the treatment of fractures, and we seldom use more than one splint for the accomplishment of these ends."

Now, as to extension and its retention, in order to produce immobility by muscular contraction, I know of no authority which has taught this, and if Dr. Gibbs has practiced it, why did he keep his light "under a bushel?" And if I rightly understand surgery, as taught in the books, the only fracture to which extension was applied to any extent, is the femur, and that, at most, extended only normally, and then it is sought to maintain it in position by compression with bandaging and short splints, placed around the thigh—while Dr. Swinburne only claims that extension and its maintenance "without splints" is all that is requisite to produce perfect results. And as to Doctor Gibbs seldom using more than "one splint in the accomplishment of these ends," I have only to say, that the profession should have known this through the medium of your valuable journal long before now.

Doctor Gibbs confesses that the dressings are "simpler" and the results are "better," even though there is "no novelty about the principles." Now, to show that Dr. Gibbs had not practiced this plan of treatment of fractures without splints, he says, "*We had not supposed that simple extension was alone necessary to secure speedy and perfect union.*" Doctor Swinburne has shown conclusively that if the muscles are stretched and so retained, that the results are *invariably* good, and this, too, without splints. So that these surgeons who are "a little skeptical" in regard to "perfect success," can have such skepticism removed by a careful examination of the cases treated in this way, and the number of fractured thighs so treated now number over fifty, and still in none can there be found to exceed one-half inch, shortening; and what is still more remarkable is, that the best surgeons are unable to detect the seat of fracture, or even decide which was the injured member. The Doctor (Gibbs) infers that extension, with the possibility of motion at the point of fracture is better than extension without such possibility. I have yet to learn that a broken limb can be so extended as to avoid *any motion* at the *seat of fracture*; and I have still further to learn that any form of *splint*, either with or without extension, can be so applied as to avoid the "possibility" of motion at the seat of fracture. I will go still further, and say, that *simple extension*, where traction is made through the long axis of the bone, *figs. 1 and 3,** leaves infinitely less mo-

tion at the seat of fracture, and more at the nearest joint, than when any form of splint is "applied," and in the most approved manner, though it may be "ingeniously devised" and "well applied," or ever so "appropriate a splint." Surely Dr. Gibbs is doing the public a great favor by devising "an ingenious splint," which is to be "well applied," and by which "the patient may be off the bed in two weeks." Also, this "ingenious splint" is to effect the wondrous cure of a fractured thigh in two weeks, and "if of the leg, they need not be confined to bed at all." This statement shows either that Dr. Gibbs is in advance of the profession, and still keeps his knowledge from them, or else is writing for effect, since no medical authority describes any "ingenious splint" by which compound fracture of the leg can be treated without confinement to the horizontal position; nor that union of a fractured thigh can be effected, so as to obviate confinement to the bed more than two weeks. Nor is it true that in *fractured femur, treated by simple extension*, "the patient must be confined to bed for months." On the contrary, the bone unites in much less time than when any "light, ingeniously-devised and well-applied splint" is used, even though they be adjusted by the magic hand of Doctor Gibbs.

Doctor Gibbs states "that the muscles, in a state of tension, will necessarily fix the fractured extremities in position," and this is all we claim for extension, which, if maintained, retains "the fractured extremities," until union takes place—hence I cannot understand why an "appropriate and properly-adjusted splint is the best means of maintaining this extension," unless it be for the treatment of fractures in the upper extremities, or that portion of the lower which is situate below the knee. Even then, I deny that it is the best, nor can extension be so successfully applied as when it is made through the long axis of the bone. (See *figs. 1 and 3.*)

So far from its being true "that a splint is almost, if not quite, a necessity, to guard against motion at the point of fracture," it is really this very thing which would be likely to produce motion when the extension is effected through this splint, unless the limb is fastened to this line of extension, which is outside of the limb—not so where the extension is made through the long axis of the bone.

If Doctor Gibbs had recently visited the principal hospitals of this country, he would not have penned the objection he did to the following extract: "In *hip-disease*, the various splints recently invented can be dispensed with, by appropriate extension upon the bed." Now, the fact is, that the splints above spoken of were invented to obviate the consequent confinement attendant upon treatment. This apparatus above mentioned was constructed so as to contain the same principles and effect the same ends as the extension on the bed. Since extension and separation of the joint is the grand desideratum in "hip disease," and hence his serious objection to confinement to bed consists in "the painfulness of a

* See cuts in the first article in this number.—[Eds. MED. AND SURG. REPORTER.]

fixed position (which) would have to be endured, and the comforts of exercise foregone," and hence "*this would be no improvement.*" Now, any one familiar with this disease and its treatment, knows full well that the little sufferers not only bear this confinement well, but they become cheerful, happy, contented, gain in flesh, and are very soon relieved of all pain. The slight cost necessary for this mode of treatment for "hip disease," causes it to be looked upon with great favor in hospitals, and in private practice among those of limited means—where stern necessity causes them to forego the "*comforts of exercise,*" and thus, I trust, it would be in the treatment of fractures, where Doctor Gibbs' "ingenious and appropriate splint" would not be accessible to any but the wealthy.

The Doctor unfortunately falls into the error, so prevalent in the profession, namely, *increasing and complicating*, rather than seeking to *simplify* and set forth the *principles* which govern the treatment of broken bones—else, why should he bring in "hip disease," in order to mystify the subject he pretends to review, and hence I think it is not only "possible," but probable, that he "fails to appreciate the Doctor's meaning in some particulars;" and though he may claim "an honesty of interest," I fail to see it in that light, since he so far perverts the statement, as to say that by Dr. Swinburne's *so-called* improved method, the patient "must be confined to the bed for months." Certainly, nothing could be further from the *truth* than this statement of Dr. Gibbs, and still he claims "an honesty of interest." All who are familiar with Dr. Swinburne's mode of treatment, know that union is effected sooner, while the usefulness of the member is restored much earlier than when treated by any of the appliances previously recommended, and hence we all have reason to doubt the "*honesty of interest*" in the previous statement.

Now, in reference to fracture of the femur and its treatment, he says: "Notwithstanding the positive assertion of Dr. Swinburne, that no splints were used, 'we fail to see it so.' It seems he plays upon a word. He may not use a splint as such by name—he makes a *splint*, if the *bedstead* and the *bedding* is but the *padding*."

Here again Doctor Gibbs may claim "honesty of interest." But I trust that the profession will "fail to see it so," since from a parity of reasoning, if in field service, we should drive sticks in the ground, at a suitable distance from each other, for extending and counter-extending points, then the *stakes* and *ground* becomes the "*splint*," and the *canopy of heaven* becomes the "*padding*." Then if he cannot be made to believe that a bedstead is lighter and more convenient than a "light, ingeniously-devised and well-applied splint," I think no logic could make him believe that this field appliance is less heavy than the "*bedstead*."

The last, but not, perhaps, least, manifestation of "honesty of interest," is his Herculean effort to show that extension by a strong man on the

one hand, and the constant pulling by weights, for days, on the other, are synonymous, and the results the same. Now, while a strong man cannot make too much traction, for the reason laid down in Doctor Swinburne's paper, the pulling continuously, by means of a weight one-twentieth that of a man, might so relax the muscles as to separate the bones too much, as set forth in the review, to which he objects so seriously. These agents of power are so entirely dissimilar, that the profession *will not fail* "to see it" at a glance, even though Dr. Gibbs "fails to see it so," while he evidently intends "to play (not) upon a word" but pervert a principle; and hence Dr. Swinburne's "first and main proposition is (not) lost," and "his third objection has—weight."

JUSTICE.

THE AMBULANCE SYSTEM.

The following letter from Dr. Henry J. Bowditch of Boston, we copy from the last number of the *Boston Medical and Surgical Journal*. We are very glad to see Dr. Bowditch adding the weight of his influence to that of the medical journals, and the profession generally in bringing about a reform that is so much needed as the organization of our army ambulance corps.

"It is painful, yet it ought not to surprise us, to see how many mistakes have necessarily arisen, during this terrible rebellion, owing, first, to the utter disbelief on the part of the North in the really revolutionary views of the Southern leaders; second, to our own ignorance of the arts of war, and of the means of alleviating the sufferings incident thereto; and the third, to the fact that, in very many instances, we still endeavor to manage an army of more than half a million of men by rules of war established for a few thousands. In nothing, perhaps, have we suffered more, from the last two causes, than in the whole arrangements for the transportation and care of the sick and wounded on and from the battlefield. It would, *a priori*, seem natural that the first thought of a truly paternal government, after having made arrangements to strike a decisive blow against an enemy, would be to make most ample provision to alleviate the sufferings of those of its children who would necessarily be doomed to endure much, even under the best system that could be devised. No *extra* suffering, and every alleviation of absolute misery, should be the watchword on such an occasion. I regret extremely to feel that, judged by this rule, our government has heretofore totally failed in one department, at least, of its service, viz.: the ambulance system, or no system, as it may more properly be called.

The extraordinary statements by Dr. Coolidge, Medical Director at Centreville, that the drivers of the ambulances broke into the hospital stores, drank the liquors and would not help the wounded until whiskey was given; my own account

(see this JOURNAL,* Sept. 25.) of the abominable misdeeds of these same or similar miscreants, during our excursion to relieve the starving and wounded at Ohantilly, near Centreville; and finally, numerous individual statements (*New York Times* and also *Medical Times*), confirmatory of the same fact or gross misconduct, and of the essentially degraded character of most of these drivers; all these things are my reason for bringing the subject again before the readers of the JOURNAL. *Some change must be effected.* I am thankful to see that correspondents in different journals in this city and New York, are discussing various plans, and as the great object we now ought to have in view is to have some plan, instead of chaos, as at present, I write the following brief abstract of what foreign governments and our own have done in the premises, and will finish with giving what I know to be the carefully thought-out suggestions of the present humane and able Surgeon-General Hammond.

On the 2d of April, 1855—only seven years ago—Jefferson Davis issued his instructions to Majors Delafield and Mordecai, and Capt. G. B. McClellan, to visit Europe for the purpose of learning everything possible, relative to modern systems of warfare. The Crimean war was then in full operation, and Sebastopol was besieged. Every subject connected with the carrying on of war was carefully suggested for investigation in the instructions given to the Committee. One item among them was as follows:—"The kind of ambulances or other means used for transporting the sick and wounded."

Capt. (now United States Major General) McClellan, makes no allusion to the subject in his "Armies of Europe." Of Major Mordecai's opinion, I know nothing. But the following, from Major Delafield's report (*Senate Document*, June, 1860), becomes important in considering the question of what we should do, in the present emergency.

Major D. says, page 68, that "never before was so much attention paid to this branch of the military service" as during this celebrated siege, and in front of Sebastopol. And in this connection he pays a high tribute to that remarkable woman, Florence Nightingale, "as the foundation of power, from which all the new arrangements and appliances emanated." It seems that several kinds of carriages were used among the allied and Russian armies, according to the ideas of those having the control of each. The smaller ones, those capable of passing and repassing anywhere, were the best. Wrought-iron chairs or litters, two hung like pack-saddles upon mules' backs, were of great service. One hundred and sixteen chairs or litters were in use at the bloody battle of Inkerman, and sufficed to transport all the men in a very short time after the action terminated; "proving," says Major D., "that they combined greater advantages than any previous arrangement."

The English organized a "brigade for hospital conveyance"—(*Report*, p. 75), which was new in

* *The Boston Medical and Surgical Journal.*

personnel and material. Its train consisted of twenty carts, five store wagons, one forge cart, and one cart for stoves and portable forge." The carts were for two, the wagons for four horses. The whole were for twelve regiments. The plan was contrived so that where a gun could go, a carriage could follow.

The following extract (p. 76), I desire to bring to the notice of the reader. Jefferson Davis undoubtedly took counsel from the whole of this valuable report, in plotting his treason. Our Government seem to have lost sight of its valuable suggestions, in one instance, at least, as is now well proved:—"The whole of this train was under the *Staff-Surgeon* of the division; none of the wagons, carts or drivers being subject to the orders of any other department, except with the authority of the General of Division, who best knew when to break up or sacrifice any part of his entire means of transport. *This provision is worthy of our attention. The details and requirements of this part of the service should not constitute a part of the general transport service of the army, as heretofore has been the case in our service. No person can so well preserve the efficiency of the surgical and medical apparatus, as he who best knows its uses.*"

The italics are my own, and I would simply add that there never was a more striking exemplification of the truth of these remarks by Major Delafield, than what I saw, in striking contrast to them, during my recent ambulance journey to Centreville. Among other things, at that time, I observed that of the small casks intended for water, and two of which were prepared for each wagon, not one seemed to contain water; and I was informed by the army surgeon in command, that they all leaked! What does the Quartermaster care for them? The absolute need of water for the thirsty, wounded or dying soldiers, would never be dreamed of by that officer. It is the surgeon alone who sees, and as it were feels, the agony the wounded soldier suffers, when deprived of this luxury.

The personnel of this English train consists of one Sergeant Major, four other non-commissioned officers, and sixty-nine drivers—total, seventy-four persons to twenty-seven carriages, or scarcely three to each carriage; "which," adds Major D. (p. 76), "gives the smallest admissible number of supernumerary drivers." All the nations of Europe "have their own ambulance and hospital store wagons, each possessing its peculiar merit, adapting them to their respective armies." In addition to these, the *Staff Surgeon*, while on the march, has a mule with "capital instruments" attached to his immediate service.

What ought we to do? Certainly we ought to adopt all the good which past experience has shown to exist in any of these ambulance corps, or modify them to suit the peculiar conditions of our army.

A plan has been devised by the Surgeon-General of the United States Army, and months ago was urged upon Secretary Stanton, and declined by him and General Halleck. Since the terrible

sufferings, lately endured by our soldiers, and foretold in a great degree by Surgeon Hammond, that gentleman has again urged on the government the necessity of some action. The government still delays, or if it has acted officially, it is only within the past week or two, and, so far as my knowledge extends, nothing has yet been publicly done in the matter.

I well know that reports come to us through the public prints, that General McClellan is doing something about it. I have, from official sources, learned that the plans of General McClellan are, as it is thought, "insufficient. 1st, Because the drivers, &c., are simply soldiers detached for the purpose; and, 2d, the plan is not sufficiently comprehensive."

What the Surgeon-General wants, "is a corps composed of men especially enlisted for Hospital and Ambulance service, with officers commissioned purposely to command them, and who shall have the entire charge, under medical officers, of the ambulance wagons, transport-carts, &c., and all the many departments of hospitals; a corps upon the basis of two men to each company of one hundred men, a hospital Captain, two hospital Lieutenants, and five hospital Sergeants, to be drilled, uniformed and equipped according to certain regulations. The whole should be commanded by a Hospital Commander. This is substantially the plan followed in the European armies."

Will not our government allow this, or some other beneficial plan, to be followed out?

HENRY I. BOWDITCH.

NEWS AND MISCELLANY.

An Order to Surgeons.—The following circular order has been issued from the Surgeon-General's office to the surgeons in charge of the hospitals:

Surgeon-General's Office,
Washington City, D. C., Oct. 6, 1862.

SIR: General Orders, No. 5, Headquarters Defences of Washington, render necessary the following modifications in the letter from this office of the 29th ult., on the supply of certificates of disability given from General Hospital.

Certificates of disability to accompany applications for furlough may be given by Surgeons in charge of General Hospitals, and in each hospital by the Surgeon in charge, only under the following circumstances:

To officers and enlisted men in cases of disability arising from wounds received in action, or in cases of disability arising from sickness, where, in the opinion of the Surgeon, change of air may be necessary for recovery.

In giving certificates of disability for furlough, Surgeons are directed to use the soundest discretion, giving them in no cases but those above cited, and noting on the face of the certificates the cause of the disability, and if it be from sickness, the necessity for a change of location. Such certificates will not be given for a longer period than thirty days.

Certificates of disability for furloughs will in no

instance be placed in the hands of the applicants or of their friends, but will be transmitted by the ordinary military channels of communication to the Medical Director, by whom, if approved, they will be sent to the Headquarters, from whence they will be returned to the hospital of which the man is an inmate.

Certificates of disability for discharge will be given according to previous regulation and according to General Orders No. 36, current series modified by notes of August 20.

Very respectfully, your obedient servant,

(Signed)

JOSEPH R. SMITH,

Acting Surgeon-General.

Medical Department of the West.—The following circulars and orders have been issued by the Assistant Surgeon-General.

CIRCULAR.

Assistant Surgeon General's Office.
Saint Louis, Mo., October 2d, 1862.

SIR: The various reports required for the information of this office have not been regularly received. The following specific instructions are issued for the information and government of the Medical Directors, appointed at the Headquarters of the Departments and Districts, which are comprised within the jurisdiction of the Assistant Surgeon General.

Having been announced as Medical Director of _____, you will immediately issue such instructions to the Medical Directors of Army Corps and Divisions under your supervision, as will insure from them such promptness and regularity in their reports as will enable you to forward to this office, always in due time, the complete consolidated reports and returns required from you.

You will forward to this office monthly consolidated reports of sick and wounded, in accordance with the form prescribed by existing regulations. Consolidated monthly returns of Medical officers in conformity with Form 17. Medical regulations giving *all* the information required in the "note," appended to the Form.

The quarterly reports of sick and wounded will be forwarded directly, as heretofore, to the Surgeon General. You will instruct, however, the Medical Officers in charge of the General Hospitals in your department to forward to this office, duplicates of the weekly reports required by the Surgeon General. So much informality, neglect, or delay has heretofore prevailed in the transmission of the required reports, that it is necessary for you to enjoin upon all concerned, that promptness and regularity is in future demanded. The reports required to be consolidated in this office are expected by the Surgeon General in due time and proper form. Failure on your part to forward the reports from your department must be reported to the Surgeon General, and it is expected that you will enforce the same system of accountability, and individual responsibility upon all under your direction.

Very respectfully, your obedient servant,

(Signed)

R. C. WOOD,

Assistant Surgeon General.

Assistant Surgeon General's Office.
St. Louis, Mo. October 4th, 1862.

In consequence of the addition of the State of Ohio, to the Medical Department of the West, under the jurisdiction of the Assistant Surgeon General, the following re-organization of the districts previously assigned to the Medical Inspector is made:

District No. 2. Lieut. Col. C. C. Keeney; Illinois, Wisconsin, Michigan, Minnesota and Iowa. Location when not on Inspection duty, Chicago Illinois.

District No. 3. Lieut. Col. G. H. Lyman; Ohio, Indiana and Kentucky. Location when not on inspection duty, Cincinnati, Ohio.

District No. 4. Lieut. Col. G. T. Allen; Tennessee, Arkansas and such parts of Mississippi and Alabama, as may be occupied by the Federal Armies. Location when not on inspection duty, Jackson, Tennessee.

(Signed)

R. C. WOOD,
Assistant Surgeon General.

CIRCULAR.

Assistant Surgeon General's Office.
St. Louis, Mo. October 5th, 1862.

By order of the Surgeon General, the following circular is published for the information of the Medical Officers, in the Medical Department of the West.

The practice indulged in by some subordinate Medical Officers, of placing in the hands of unofficial persons, irregular certificates of disability, has come to the notice of the Secretary of War, and received his strongest disapproval.

The attention of Medical officers is called to General Order No. 78, current series, in which furloughs and transfers in individual cases are prohibited.

The Secretary of War had instructed the Surgeon General to report to him, for dismissal, the names of all Medical Officers who in future may give such certificates of disability, or recommendation for transfer, except in cases of life and death.

(Signed)

R. C. WOOD,
Assistant Surgeon General.

Special Medical Orders.—Assistant Surgeon B. A. Clements, U. S. Army, will report in person to the Medical Board in Philadelphia for examination and promotion.

Surgeon Ira Russell, U. S. Volunteers will report in person to the Assistant Surgeon-General in St. Louis for orders.

The following assignments are made of medical officers.

Surgeon Paul B. Goddard, U. S. Volunteers, to report in person to Surgeon W. S. King, Medical Director, Philadelphia.

Surgeon D. H. Agnew, U. S. Volunteers, to report in person to Surgeon W. S. King, Medical Director, Philadelphia.

Surgeon A. B. Crosby, U. S. Volunteers, to report in person to Gen. McClellan's Headquarters.

Surgeon J. Hopkinson, U. S. Volunteers, to report in person to Gen. W. S. King, U. S.

Army, Medical Director, Philadelphia, to take charge of the Chesnut Hill Hospital.

Surgeon Clayton A. Cowgill, U. S. Volunteers, to report to Newbern, N. C., and relieve Surgeon G. Derby, Twenty-third Massachusetts Volunteers, in charge of the Academy General Hospital in that city; Surgeon Derby when relieved will join his regiment.

Surgeon P. P. Breed, U. S. Volunteers, to repair to Newbern, N. C., and relieve Surgeon G. A. Otis, Twenty-seventh Massachusetts Volunteers, in his duties at that place. Surgeon Otis when relieved will join his regiment.

Surgeon S. D. Truman, U. S. Volunteers to report in person to Surgeon Simpson, U. S. Army, Medical Director at Baltimore, and to relieve Surgeon R. M. Pease, Tenth New York Volunteers, in charge of General Hospital Patterson Park.

Surgeon Israel Moses, U. S. Volunteers, to report to the Medical Director at Washington, D. C., for duty in Harewood Hospital.

Assistant Surgeon S. S. Mulford, U. S. Volunteers, to proceed to Point Lookout, Md., and report to Assistant Surgeon C. Wagner, U. S. Army in charge.

Assistant Surgeon F. A. Keffer, U. S. Volunteers, to report in person to Surgeon W. S. King, U. S. Army, Medical Director, for duty at West Philadelphia Hospital.

Assistant Surgeon A. Major, U. S. Volunteers, to report in person to Major Gen. Mitchel at Hilton Head S. C.

Assistant Surgeon G. A. Wheeler, U. S. Volunteers, to report in person to Surgeon T. A. McParlin, at General Hospital, Annapolis.

Assistant Surgeon W. Moss, U. S. Volunteers, to report to Surgeon Letterman, Medical Director, Army of Potomac for special duty.

Assistant Surgeon J. H. Brewer, U. S. Volunteers, to report in person to Surgeon T. A. McParlin, U. S. Army, General Hospital at Annapolis, Md.

Assistant Surgeon L. S. Sutton, U. S. Volunteers, to report to the Medical Director at Washington, D. C., for duty in the Douglas Hospital.

Assistant Surgeon P. Cleary, U. S. Volunteers, to report to the Medical Director, Washington, D. C., for duty at the Carver Hospital.

Assistant Surgeon A. H. Sheldon, U. S. Volunteers, to report in person to the Medical Director at Washington, D. C., for duty at his office.

Assistant Surgeon G. E. Patle, U. S. Volunteers, to report to the Medical Director, Washington, D. C., for duty.

Assistant Surgeon W. A. Connover, U. S. Volunteers, to report to the Medical Director at Washington, D. C., for duty in the Armory Hospital.

Assistant Surgeon U. S. Fernk, U. S. Volunteers, to report to the Medical Director at Washington, D. C. for duty in the Carver Hospital.

Surgeons H. J. Churchman, H. A. Martin, Barton Darnack, and Assistant Surgeons C. Van Duzen, L. B. Davis and E. Dodd, U. S. Volun-

